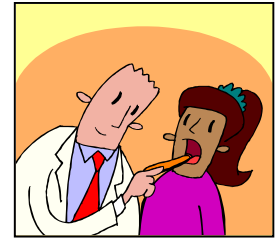


# ORAL HEALTH SCREENING FORM



Location: \_\_\_\_\_

Grade/Teacher: \_\_\_\_\_

The screening was completed by: \_\_\_\_\_

Date: \_\_\_\_\_

Name	Treatment Urgency		
	0	1	2
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#0 Treatment Urgency = No obvious oral health problems; **Routine** dental care recommended.

#1 Treatment Urgency = Observable oral health problems; **Early** dental care recommended.

#2 Treatment Urgency = Presence of pain, swelling and possible infection or three or more areas of possible decay; **Emergency** dental care recommended.